



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

ANESTHESIA ALLIANCE OF DALLAS, P.A.

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-17-1573-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

JANUARY 27, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier has issued a payment for our service but not the correct allowable per the 2016 Texas Workers Compensation fee schedule, FOR A Certified Registered Nurse Anesthetist claim."

**Amount in Dispute:** \$53.41

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2016	Anesthesia Services CPT Code 01400-QZ	\$53.41	\$51.13

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - P12-Workers' compensation jurisdictional fee schedule adjustment.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 6, 2017. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the

division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

### **Issues**

Is the requestor entitled to additional reimbursement for code 01400-QZ?

### **Findings**

28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code 134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other.

28 Texas Administrative Code §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$53.68..."

The requestor billed CPT code 01400-QZ defined as "Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified."

The requestor billed the disputed anesthesiology service using the "QZ" modifier that is described as "CRNA service: without medical direction by a physician."

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

The Division reviewed the submitted medical bill and finds the anesthesia was started at 0900 and ended at 1014, for a total of 74 minutes. Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(G) states, "Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place." Therefore, the requestor has supported  $74/15 = 4.93 = 4.9$ .

The base unit for CPT code 01400 is 4.

The DWC Conversion Factor for 2016 is \$56.82.

The MAR for CPT code 01400 is: (Base Unit of 4 + Time Unit of 4.9 X \$56.82 DWC conversion factor = \$505.69. Previously paid by the respondent is \$454.56. The difference between the MAR and amount paid is \$51.13, this amount is recommended for reimbursement.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$51.13.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$51.13 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	4/4/2017
Signature	Medical Fee Dispute Resolution Officer	Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**